AZ HIPAA Medicaid Consortium

Dec 18, 2003
3:00 PM to 4:30 PM
AHCCCS 701 E. Jefferson St. – 3rd Floor - Gold Room

Meeting Hosted By: Lori Petre, AHCCCS

Attendees:
(Based on sign-in sheets)

ADHS/BHS	**Care 1st Arizona**
Thomas Browning	*Bill Hobbs*
Lee Cisney	**DES**
Brian Hiese	*Marcella Gonzalez*
CJ Major	*Bonnie Ann Smitt*
Jeri Gray	*Stan Hime*
AHCCCS	*Nicole Yarborough*
Ester Hunt	**Evercare Select**
Peggy Brown	*Vicki Johnson*
Deborah Burell	*Jane Fowler*
Matt Furze	**Healthchoice AZ**
Mary Langan	*Paul Benson*
Carrie Stamos	*Ethan Schweppe*
Pat Spencer	*Mike Uchrin*
Tom Forbes	**HCSD**
Ted Kowalczyk	*Michael Wells*
Dennis Koch	**MCP & Schaller Anderson**
MaryKay McDaniel	*Art Schenkman*
Nancy Mischung	*Joginder Singh*
Mariaelena Ugarte	*Cathy Jackson-Smith*
Linda Stubblefield	**Pinal LTC**
Marsha Solomon	*JoAnn Ward*
Dave Mollenhauer	**PHS**
Melonie Carnegie	*Mark Hart*
Chris Herrick	**UFC**
APIPA	*Kathleen Oestreich*
Lucy Markov	*John Valentino*
Charles Revenew	**Yavapai County**
Sean Stepp	*Dave Soderberg*
David Wormell	

1. Welcome (Lori Petre)

We apologize for the rescheduling of the Consortium Meetings that has occurred. We will try to stick to the regularly scheduled meetings from here on out. The only change may be that we are going to evaluate our progress with Encounters, and we will talk about Encounters towards the end of the agenda, and determine if another meeting between now and 1/21/04 would be helpful.

We have got a lot on the agenda. We did not want to keep you here too late so we are going to shorten the meeting to an hour and a half today, and we will get us much as we can done.

2. 834/820 Follow-up (Lori Petre)

Status of where we are from our side. On our side, we are still supporting the contingency. For those health plans still operating under a contingency, if you will be operating under a contingency beyond the 31st of December, I will be scheduling a follow-up meeting with you, and you will receive a letter outlining the Corrective Action Plan. We are required to report to CMS on a weekly basis where we are with each transaction with our key Trading Partners so this information is important.

The other thing about the 834/820 is, as of right now, we will stop the parallel runs as of 12/31/03. The 31st will be the final parallel run as the schedule now stands. That is why we need you to say in your contingency "what are the things that we need to do to help you be successful in implementing these transactions".

On the second page of the Milestone chart, which should be your first handout, we just wanted to give you a status. These are not transactions that you interface with us, but we do share providers so it is nice that you know where we are with some of our provider transactions so that you have an awareness.

We implemented the batch component of our 270/271 Transaction on Tuesday morning, 12/16/03. We had implemented the online in October 2003, but we had held the batch transaction pending external Trading Partners testing of this process.

The only remaining transaction that we look to implement are the Encounters, which we will talk about, and the 276/277 Transaction which we are going through one last time to make sure that everything is ready for external testing. We will be rolling that out for some Trading Partner testing soon. We have actually lined up some providers to test that with us, and we hope to begin that in the next week or so.

We did implement the 835 and 837 Transactions. We are supporting contingency plans for our fee-for-service providers for those transactions. CMS is much hotter on this issue of getting our fee-for-service providers converted over so we are getting a little more pressure from them on that one.

Q: Has AHCCCS come across any cheaper, smaller billing packages?
A: There are a couple of providers that we are hearing from just this week whom we have put off probably a month or so ago. I think they thought we were going to supply some solutions which none of us have had the budget to do so. Native Resource Development called this morning to say that they had found some software so we can certainly check on that. There are some clearinghouses that are marketing to some small providers. There is one that is doing a lot of the nursing homes, and they are just doing a bang up job. They are coming up within two or three days, and it seems to be cost effective for them. We can certainly share with you who we have certified and who those entities are because what we do is we make that available to these providers that are saying they don't know what to do.

Action Item: Lori Petre
Follow-up with list of certified clearinghouses.

Health Plan - Health Choice is kind of looking at if from a different perspective. We are getting a lot of providers that are with a lot of different clearinghouses. We are finding that the clearinghouses will only send on claims to health plans that they have contracts with. We are finding that with some of the clearinghouses the startup costs are pretty high, and then we are looking at the per transaction cost.

Q: What are other folks doing when finding we cannot contract with all clearinghouses? What did you work out with your CEO? One concern is that the clearinghouse is holding onto these claims and not sending them on. The other concern is the larger health plans who can contract with six or seven major players that the providers are going to start telling their members, when open enrollment comes up, that they can bill easier through this plan, so we want to address these concerns.
A: That really is more of an issue at the health plan level. At the fee-for-service level, we take any willing submitter. We will register 50 clearinghouses and go through testing with them. We have kind of a different process, it isn't really a contracting, it is more of a registration process so we don't have that circumstance.

Q: Is AHCCCS sponsoring those transactions?
A: No. We are requiring them to have the clearinghouse do the registration, which is pretty simplistic, and then go through a testing phase. Then we are certifying the submitter so we are certifying the clearinghouse.

Q: So if I am Tom and Jay Medical Group, and I want to go through WebMD, and WebMD is already certified, I can do so?
A: Yes.

Q: But AHCCCS is not covering the cost, the provider is covering the cost?
A: No, AHCCCS is not covering the cost. They need to understand that you represent a Medicaid agency, and you are under no obligation to pay them to process.

Q: Is there an outreach that AHCCCS can do for providers or is this something that should be brought up at CEO meetings?
A: We can certainly make note of it. I will talk to Kari Price and Nan Jeannero, and see if we have any ideas. Certainly we are more than happy to try to do some public relations with the clearinghouses. Most of the large clearinghouses everybody is going to share.

Action Item: Lori Petre
Follow-up with Kari Price and Nan Jeannero.

MaryKay stated that at the Healthcare Integration Group, this was a topic of conversation about two meetings ago. They had some solutions on there that were some actual statements that they made out of the rules. Maybe we could help provide them with that.

If it is not too late, I will check the status of the letter from Kathy Byrne to see if a piece can be added regarding this to make sure that providers clearly understand that the health plans are part of the same program.

Action Item: Lori Petre
To check their (Healthcare Integration Group) website to see if she can pull together this information.

The hospital clearinghouses on a National level are giving everyone problems. CMS is looking at them specifically. If you are having specific issues with one of the five hospital clearing houses, let me know because one of the things I have to report to Jenny Chen, who is our CMS Representative, every week is where those clearing houses are performing of under performing in our state.

SSI Group has been testing with us off and on. They will be real aggressive and send us files for a couple of weeks, and then all of a sudden, they will disappear. NDC we have not gotten to test at all. Hawaii uses NDC; they were their first provider certified. I don't know if they are focusing on certain markets or exactly what is happening.

We will look into this a little further. Part of the purpose of the Consortium is to allow you a venue that you can share those things. If you want to send it through us and have us send it out to everybody, we are more than happy to do so.

834/820 Issues (Tom Forbes)

There are only two issues that we really have. The other issues we did have were in the companion document regarding the missing 834 translator maintenance reason codes. The companion document was updated accordingly and is currently on the website. Pima, however, sent a couple of issues to us.

There was an issue with share of cost, and that was in the LEDS/CATS system compared to the Recipient system. Actually, the LEDS/CATS and our ACE system, moved the share of cost to the Recipient system. Unfortunately, the costs were not the same when they showed up on their files. They did make a change and fixed the LEDS/CATS side, but the Recipient tables still has not been updated and fixed. Until they get that done, which the programmers say there is not a task to fix the table as there is still discussion on how to fix it, there is going to be discrepancy in some of the share of cost codes from the Recipient system to LEDS/CATS system. What is ending up in the 834 is not correct; the LEDS/CATS system is correct. The share of cost amount on the 834 file is higher than it should be.

The other issue was that Pima had said that they were seeing a high volume of TPL records that show as AIs. These TPL records are actually just informational TPL records and not changes that are caused by a Bendex file sent monthly. This problem is creating a lot of extra work for the health plans.

Health Plan – The volume is irregular. We will be going along and suddenly we will get a 100-200 records, and the staff have to go through them, because one of those records may have valuable information. They are saying that 99% of the time it is the same thing they have gotten in the prior file. They do not understand why all of a sudden there are these huge volume swings as it was not like this prior to 10/1/2003.

Q: TPL is still in proprietary, when is that changing?
A: It is still on your 834s in test.

There has not been a change in system volume; we need to follow-up with someone on the Recipient team.

Action Item: Dan Lippert
Why are there such huge volume swings on the TPL files all of a sudden?

We need to look at the matrix that was submitted at the last meeting, of which files became HIPAA and which remained. Per MaryKay the TPL file was going to continue since there was additional information on the TPL file that was not available on the 834. The health plans have the option of using the COB information on the 834 or relying only on the TPL files. The information should be the same, they are just getting more of it on the TPL.

We will take these three issues Mark Hart with Pima Health submitted via email and generate tickets so you will receive formal responses, but you had asked that we talk about them today so we wanted to make sure and do that. We will share the formal responses with the group.

Action Item: Lori Petre.
Tickets to be generated on these three issues from Mark Hart with Pima Health.

3. Follow-up Items

Local Codes (Brent Ratterree)

Emails have gone out. To our knowledge local code issues have been settled.

Acknowledgements

Nothing new.

Co-Pays (Nancy Mischung)

Co-Pays continue to be a topic here at AHCCCS as it has been implemented and rolling out. The management team working on it has requested Nancy to ask two questions:

The first one is they wanted to see if they could get any feedback on the implementation of co-pays in general as far as are the health plans implementing them; are they putting them into their system, loading their system with them? Are they passing them on to their providers?

Health Choice stated that they have automated the mandatory co-pays in the adjudication system as well as having posted them on their web site, and they have passed them along to their PBM.
Pima Health indicated that they have done the same.
Mercy Care indicated that they are still working on it, but they do plan on implementing it.
Phoenix Health Plan is working on it with the intention to put it in their system and pass it along.

The second question, because one of the things that has come back to them in feedback is that when a new add comes on, we put that up and we assign the co-pay at the time. If the add comes in on, say the 10th of the month, the situation that we are encountering, and it happens a lot with Behavioral Health, is that now that we bring that eligibility up, and we get a match from Behavioral Health two or three days later, and now it is acknowledged as Behavioral Health, it should be a lower co-pay. Now they have got a co-pay, because we only post the changes at the end of the month, that is basically higher than what it should be. We are looking at systematically doing changes as they take place. In other words, where today you are only seeing your co-pays on an 834 (on your Daily, if it is a new add; if it's a change, on the last Daily of the month). What we are proposing, and we are supposed to get feedback from you if you can handle it, because we are not going to implement it if you can't handle it, but what we are proposing is you could potentially have a co-pay change on your Daily.

Q: So based on how you have put this in, those of you that have put it in, could you handle that?
A: Yes, because it is coming off of the 834.

Q: What do you mean by the amounts of their co-pay will be reduced? Do you mean they went from mandatory to optional?
A: They could go from mandatory to optional or mandatory all the way down to none. General mental health is optional and SMI is zero.

Q: When we get the changes, will there be an effective date tied to it?
A: Yes, but we needed to know if you thought you could handle it first. If you can handle it, we will work the details, like the effective date, out. Right now, one of the big concerns is there is not an effective date tied with it on the 834. If we started changing them on a daily basis, you would have to have an effective date tied to it. We would have to look at that.

The health plans indicated that it was doable, but they would have to have an effective date.

4. Other (Lori Petre)

Open Issue/Action Items

We only have one open Action Item from a prior meeting. It is on the evaluation of the U277. We are going to talk about the U277 under Encounters. Hopefully we will be able to close this one relatively soon. Also included in your packet is the Problem Report Status. Does anybody have any other questions not related to Encounters?

Q: The question is on Acknowledgements, because in our tests we have never had anything fail. What happens if we did get an Acknowledgement and it fails for some reason? What would we do at that point.
A: In production we are paged, and we will contact you to review the problem.

Q: If it is over 24 hours, what should we do?
A: Operations has a process in place that requires them to make telephone calls to have the issue elevated until it is resolved.

Q: Do you have the correct number to contact us available?
A: We probably want to revisit the health plan contact list that Dan Lippert's team has. We had talked about doing that sometime soon because a lot of the times for HIPAA we have been operating under a separate contact list. I always try to make sure that I use that when I send something out, but in some cases we want to make sure that we are canvassing the right people.

Q: When we go into production, isn't that part of the process?
A: Yes, at that time we would update our contact list.

You can also contact ISD Customer Support who will open a ticket for production issues, which then goes through the same escalation process.

Q: Is there anything new on the electronic signatures and the BBA certification?
A: (Nancy Mischung) Right now I have a paper on my desk with five options and a recommendation. I like the recommendation. I have one open question back to the group that is doing it on Brent's behalf because of what we are going to be talking about with Encounters. The question is do we go ahead and implement it before we implement Encounters? We are going to get that answered. We will meet with Brent on the recommendation, and we are confident that we should be able to get this update. We are not looking at true digital signatures. We are not looking at additional software or anything like that based on legal advice. We should be able to give you more information on what the recommendation is at the next Consortium meeting. We definitely have an option to get away from faxes.

It was noted that other states have been inquiring on how AHCCCS intends to handle this. Per Brent Ratterree, he has had a few states call to ask what we are doing in this area.

Q: Will there be anything on how AHCCCS is implementing the HIPAA Security Regs?
A: We forwarded this issue to the folks that are handling that component to make sure that you got the most current responses on those questions. Mel will follow up and get back to you.

Action Item: Melonie Carnegie
To follow-up on this open issue.

As far as the next meeting, it is scheduled currently for the 21st of January. We will assess if we need a meeting in between. If not, you will receive materials via email regarding data certification and some of those things.

5. Encounter Discussions (MaryKay McDaniel)

Project Schedule (Lori Petre)
We are behind on development related to Encounters. Resources have been reallocated with reasonable testing windows.

The next thing in your packet is the revised Milestone dates. These dates are not expected to change. If we can come in earlier than these dates, we will certainly do so. Instead of implementing in January it will be March. The calendar has been revised as well so you can see where the dates fall as far as when system and integration testing will occur, when Trading Partners testing will occur. That window can be expanded. We will certainly support anybody testing beyond that if we need to. And then the implementation dates as associated with the cycle.

837 Encounter Companion Document
Q: When will the 837 Encounters Companion Document be finalized?

A: The Milestone schedule currently reflects 5/15/04, and it should read 4/15/04. It always lags a month. We allow the transaction to be up and running for a month before we say the document is finalized. Otherwise you are getting a revised final every three days.

We have incorporated pretty much all the statements that we know of into the 837 Encounters Companion Document. Any changes should come as a result of something we thought we could do in the design of it, and it turns out that we cannot or things that will come out of testing, and that should be it.

Q: Can I take this copy of the companion document and give it to my developers for the 837 Encounters?
A: We are clarifying statements in the document. which will not change anything.

Q: When can it be published to the HIPAA website?
A: It could be possibly tomorrow. We need to negotiate with Web Services to get it published tomorrow.

Action Item: Melonie Carnegie
Have the 837 Encounter Companion Document published as an emergency on the HIPAA website by Friday, December 19, 2003.

U277

The U277 is still very much in draft form. I was told prior to the meeting that this document is still being tweaked, and that it is very much a draft version.

We will give you some time to take this packet of information back and digest it. Do send any questions that you might have via email. Let us know if you have questions or concerns about this. I think that Brent was walked through it in just the last several days so he may have some follow-up questions. As I said, Jim Wang did meet with Eric so we were hoping that it had funneled down to all of you, and we apologize if it did not. With DHS, I will be sending you an email. We are gong to start trying to run through your files, and we have feedback on the ones that you have sent us already. We are not going to just sit and hold your stuff and not do anything with it; we are going to work with you in this interim time to try and get you set up so that when you go live, you will know that those files are going to go through and what they will do.

Encounter Examples (MaryKay McDaniel)

What I would like to do is walk through the examples in the packet, line-by-line, loop-by-loop, if we could. You had some questions, and I as we go through there, I would like to bring those questions up and give you an answer.

What we have are four examples that I think should cover the majority of the Encounters. We know that we need a DME example. We know that we need a Purchase Service to kind of show you who it is going to work. It seems there has been some confusion on how they need to really look so I am hoping I can clear that up today. If people have questions, we can have some fun conversations about these examples.

837 Professional Example

Loop ID – 1000A Submitter Name

Submitter Name is Arizona Medicaid Health Plan with the health plan ID of 123456 as their AHCCCS six digit ID number; their TSN is 123, and the input mode is a 2 for New Day. I would like to point out that it is there in the NM109. We used 46 as the Qualifier for that.

Loop ID – 1000B Receiver Name

The Receiver is going to be AHCCCS, and the 46 Qualifier is going to be the AHCCCS Tax ID number.

Begin Claim 1

Loop ID – 2010AA Billing Provider Name

The 2010AA is the Billing Provider. The Billing Provider, in this situation, is going to be who got the check. It does not necessarily have to be the Servicing Provider; it is the Billing Provider.

Q: What about a REF segment?

A: In the situation where the 2010AA is not the actual the Servicing Provider, we do not need it. But I do have an example that I put in for just that question. If it is not required, because that is not considered the Servicing Provider to us, we use the Tax ID off of this Provider.

The Billing Provider Name in this situation was ABC Medical Clinic.

Loop ID – 2000B Subscriber Information

The Subscriber Information is kind of confusing. There have been several questions on this one. The 2000B belongs to the destination provider or payer. In this situation where a health plan that has made a payment or denial is sending it to AHCCCS reviewing it as a secondary. We are treating the whole Encounter process as a coordination of benefits encounter. In this situation on the 2000B Loop there is no other payer other than the health plan so AHCCCS would be the secondary. The SBR01 is S for Secondary.

I did run a test, and you can have three different tertiary payers out there; it doesn't care. It only allows for primary, secondary or tertiary so if there were two other payers plus the health plan and then you are sending it to AHCCCS, you are going to have a primary, secondary, and a tertiary payer, and AHCCCS is also going to be seen as tertiary. They did not go any further than that; the transaction allows for it, and it gets through.

The ending the element there is an MC; I used Medicaid because in this situation you are sending it to a Medicaid plan. That will change as we get into the other loops.

Loop ID – 2010BA Subscriber Name
The Subscriber Name was Mr. Alton James.

Loop ID – 2010BB Payer Name (destination payer)
The destination payer for the 2010BB Loop was AHCCCS.

Loop ID 2300 Claim Information
The 2300, the Claim Information Loop, which we consider to be the beginning of the header information, the CLM01 is the Patient Account Number. That is what, and everything else that you see, gets treated as the Patient Account Number. If the U277 calls for a Patient Account Number, that is the field that gets sent back. There is a separate place that has the actual health plan ID number on it, but the CLM01 is what is going to be coming back. The request that we had for including the Patient Account Number, and making that truly the Patient Account Number was for Encounter validation. If it is truly the providers Patient Account Number, when they do validation, it should be easier to go back to the Servicing Provider and say "here is the member, here is your Patient Account Number, give me the medical records". That is the theory behind that.

Q: We will get the patient account number on the U277 instead of the claim number?
A: You will get both. The way the specs are currently mapped on the U277, the first loop will have the Patient Account Number, and the second identical loop will have your actual claim number.

The total billed charges for this claim happen to be $60. It was an Office 11. The Date of Service was 12/14/2001, and it was a Capitated Claim. The CN1 is an 05 indicating that it was capitated.

Loop ID - 2310B Rendering Provider Name
The 2310B is the Rendering Provider Name. In this situation there was actually a Billing Service and an actual Servicing Provider. So the 2310B Loop was who performed the service. And this one will have the AHCCCS ID number in the REF segment and the Locator Code.

Loop ID – 2320 Other Subscriber Information
The 2320 starts the other Subscriber information. There will be multiple 2320 Loops if there was another payer other than the health plan. In this situation we are saying that there was no other insurance; it was the health plan only. It was a Medicaid claim, and it got sent to the health plan. If you will notice the SBR01 under the 2320 was P (primary). The COB Payer Paid Amount was zero; it was a capitated payment. There were no dollars actually paid to the provider for this service. The allowed amount was $50.30.

Loop ID – 2330 Other Subscriber Name
The other subscriber name we would expect to see in this situation will be the same as the recipient because it is a health plan loop.

Loop ID – 2330B Other Payer Name
The Other Payer is going to be the Arizona Medicaid Health Plan. That would be whoever the health plan is. The REF with the F8 would be your health plan claim number. They have added a completely separate field on the Encounter database; they will store both the Patient Account Number and the Health Plan Number.

Loop ID – 2400 Service Line
This was a one line claim; one 2400 loop. It was for a 99212 for $60.00. The health plan approved amount was $50.30.

Loop ID – 2430 Line Adjudication Information
Now look at the 2430 Line Adjudication Information. Please note that on Professional, we are always expecting line adjudication information, at least one from the health plan. That is where the health plan is going to tell us how they paid it what they did. In this situation, there was an allowed amount of $50.30. The 42 was over the fee schedule. Basically it zeroed out; you paid nothing with the CO (Contractual Obligations) and 24 (payment for charges adjusted).

Q: Will there be a problem if 0's are in the Patient Account Number?
A: The Patient Account Number field cannot be blank. 0's can be plugged in; you could plug the claim number, client name.

837 Outpatient Example

Loop ID – 1000A Submitter Name
In this situation, the Billing Provider again is not the Rendering Provider.

All of it remains the same until we get to the 2300 Loop.

Loop ID – 2300 Claim Information
The bigger changes in the 2300 Loop for the Outpatient are the Medical Record Number, which becomes available. The primary diagnosis was there.

Loop ID – 2310A Attending Physician Name
In some situations, the Attending Physician Name is required. Don't forget that one; the little sign that you get is really ugly.

Loop ID – 2310E Service Facility Name
The Service Facility was 123 Hospital of the Sun. They were the Rendering Provider, and their AHCCCS Provider ID number was 125896. The bigger pushback does not come from the name; it comes from having to have an ID number. On hospital claims especially. You cannot fill this field with all 1s, as it is not a valid number. It will take all 9s. Providers do not like all 3s. That is one that you may hear back from your provider that they don't like. Other than these exceptions, you can pretty much put what you want into this field.

Q: Since there are not that many people here really, are you going to put that out through an email or something?
A: (Lori Petre) I have been trying to keep track of the kind of questions that I have been getting time and time again from providers, and we will try to extract some of those. This is one that the Hospital Association brings up every single time.

Action Item: Lori Petre
Will extract this one and a few others that are real frequent questions we are getting from providers and share them with you.

Loop ID – 2320 Other Subscriber Information
SBR01 is a Primary; it is a Medicaid. In this situation it is an Outpatient, the information on the CAS segment will be at the 2320. This claim was not paid at the line; it was paid at the header. The CO is a Contractual Obligation for whatever reason. They billed a total of $716.83. The health plan paid $219.56. The bottom line was that there was a contract enforced, obviously, and they didn't pay $497.27. The paid amount and the allowed amount were equal here.

Loop ID – 2330A Other Subscriber Name
The Other Subscriber is the name of the Recipient.

Loop ID – 2330B Other Payer Name
The Other Payer again was the Arizona Medicaid Health Plan. There is a Claim Paid Date and the Health Plan Claim Number.

Loop ID – 2400 Service Line
There were 7 lines for this claim. Assume it was paid at the header.

837 Institutional Example

The Institutional Example is pretty close to the Outpatient Example.

Loop ID – 2010AA Billing Provider Name
Again it was ABC Hospital Billing.

Loop ID – 2010BA Subscriber Name
Alton James has been pretty sick.

Loop ID – 2300 Claim Information
At the 2300 Loop the billed charges were $5699.44. The CN1 is added. It was a tier per diem payment so we are using the 02 for the per diem payment. The member spent 6 days in the facility.

Loop ID – 2310E Service Facility Name
The service facility was 123 Hospital of the Sun.

Loop ID – 2320 Other Subscriber Information
Again, the difference is usually seen in the 2320 Loop. We have the difference between what was paid and what was billed in the CAS segment, and there was a prompt pay discount on this one. I know that we had some questions on prompt pay discount so I actually got one in there. The health plan paid amount was $3100.00; the allowed amount was $3300.00.

Loop ID – 2400 Service Line
There are no 2430 Loops at the 2400.

Action Item: Mary Kay McDaniel
Examples to show how these would look being paid at the line.

Q: On the Institutional, are the co-insurance and deductibles in the value codes?
A: Yes, they sure are. The still have to be at the CAS segments. The CAS segments have to balance. They do not take into consideration the value codes. If the value code has a co-insurance in there, you have to have the co-insurance on the CAS as well if it lowers the payment that is actually being paid.

837 Dental Example

Dental is pretty close to the Professional.

Loop ID – 1000A Submitter Name
Need to be sure and stress that the health plan TSN and Mode needs to be at the 1000A NM109. It tells who is sending this in.

Loop ID – 2330B Other Payer Name
The second place that the health plan TSN and Mode really has to be is on the 2330B. How we pick up that it is a health plan and not a Medicare payment loop is by that ID number. We match the Submitter to the 2330B NM109, and that says to us that this 2320 Loop is a health plan loop.

Loop ID – 2430 Line Adjudication Information
The third place that it has to be is on the 2430 SVD01. When we are doing matches to say that somebody made a payment on this line, we have to match back up to the 2330B NM109 to say who made this payment. So we are matching up based upon that number again. If this had been Medicare, it would have a Medicare number in the NM109 in the 2330B, and the Medicare number in the SVD01 to match back to that particular loop.

Action Item: MaryKay McDaniel
To add more examples in this area to be dispersed prior to the next meeting for discussion in that meeting.

Regarding the 5 different applications for the 277. They just registered all the 5010's, which I noticed today. The only 277 that will handle a pended status is the 277 Unsolicited 3070 version.

The other Implementation Guide uses of the 277 specifically restrict the use of pends. The statement made in the 5010 in the overview that these are financial transactions, and you do not send a pend on a financial transaction because it hasn't been paid. That was the statement that was made.

Meeting adjourned.